

**SUNY UPSTATE MEDICAL UNIVERSITY
COLLEGE FACE SHEET GRANT APPLICATION**

Principal Investigator: MICHAEL MEGUID Department: SURGERY
Social Security No.: 015-46-3095 Telephone No.: 4646277
Co-Investigator: KOHINATA PhD Department: Surgery
Sponsor: _____
Title of Proposal: GASTRIC BYPASS IN OBESITY: GHRELIN-RELATED WEIGHT LOSS
Budget Year: _____ through _____ Amount: \$ _____
Type of Application: ☒ New ☐ Renewal ☐ Continuation ☐ Supplemental
If other than new, give present R.F. #: 211 - _____
Deadline: _____ ☐ Receipt? Or ☐ Postmark?
Performance Site:
☒ SUNY Upstate ☐ VAMC ☐ CH ☐ Other: _____
I AGREE TO ABIDE BY THE POLICIES OF THE STATE UNIVERSITY OF NEW YORK AND THE
RESEARCH FOUNDATION OF SUNY AND THE UPSTATE MEDICAL UNIVERSITY IN THE
PERFORMANCE OF THIS PROJECT.
10/1/01 Michael Meguid MD PhD
Date Signature of P.I.

Indirect Cost Rate (%): 30%
Financial Disclosure Form SUNY-2 for this application has been filed in the Dean's Office.
☒ Yes ☐ Not required Date Filed: _____

Does this proposal involve Human Subjects? ☐ Yes ☒ No
If yes, is project approved? ☐ Yes ☐ No
Date submitted to IRB: _____ IRB #: _____

SUNY Upstate applies a \$1500.00 IRB fee on corporate-sponsored protocols. This should be identified on sponsor agreement form/budget and included in a separate check made payable to The Research Foundation of SUNY.

I CERTIFY THAT THIS PROPOSAL DOES NOT DIFFER IN ITS INVOLVEMENT OF HUMAN SUBJECTS FROM THAT WHICH THE IRB HAS REVIEWED AND APPROVED.*

Date Signature of P.I.

*Any changes to an approved protocol must be submitted to the IRB prior to implementation.

Does this grant involve live Vertebrate Animal Subjects?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, is project approved?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date submitted to CHUA: _____	CHUA #: _____	
I CERTIFY THAT THIS PROPOSAL DOES NOT DIFFER IN ITS INVOLVEMENT OF VERTEBRATE ANIMAL SUBJECTS FROM THAT WHICH THE CHUA HAS REVIEWED AND APPROVED.*		
<u>10/01/01</u>	<u>Michael Reginald and Plus</u>	
Date	Signature of P.I.	
* Any changes from original approved proposal must be submitted to the CHUA office by Addendum Form.		
I HAVE DISCUSSED THIS PROJECT WITH THE PROJECT DIRECTOR AND THE DLAR WILL BE ABLE TO SUPPLY THE NECESSARY RESOURCES TO ACCOMPLISH THE GOALS OUTLINED IN THE PROPOSAL.		
<u>10/2/01</u>	<u>[Signature]</u>	
Date	Signature of Director, DLAR	

1. Does this project involve recombinant DNA	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
2. Does this project involve work with infectious agents that are potentially hazardous to man or animals? (A list of such agents is available from the Research Administration Office).	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
3. Does this project involve the use of fresh human tissue, blood or body fluids being handled in a research laboratory other than a licensed clinical pathology laboratory?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If the answer is yes to any of the above questions, the project must be approved by the Institutional Biosafety Committee.		
Date approved: _____	I.B.C. #: _____	

Does this project involve the use of radioisotopes?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
License #: _____		

I HAVE REVIEWED THIS PROPOSAL AND FIND IT CONSISTENT WITH DEPARTMENTAL AND INSTITUTIONAL POLICIES. APPROPRIATE SPACE AND FACILITIES ARE AVAILABLE WITHIN THE DEPARTMENT TO PERFORM THE STUDIES AND APPROPRIATE SALARY OFFSET (IFR/SOS) HAS BEEN REQUESTED FROM THE SPONSOR. IF APPLICABLE, COOPERATING DEPARTMENT APPROVAL IS INDICATED BELOW.

Application Approved:

10/01/2001

Date

[Signature]

Signature, Department Chair

Date

Signature, Cooperating Department Chair